

STATE OF ILLINOIS

Page 2

Facility Name & ID Number ROLLING HILLS MANOR# 11/1/2003 Report Period Beginning: ##### Ending: 10/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 1/25/2002

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>130</u>	Skilled (SNF)	<u>130</u>	<u>47,580</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>47,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>23,411</u>	<u>16,728</u>	<u>5,200</u>	<u>45,339</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,411</u>	<u>16,728</u>	<u>5,200</u>	<u>45,339</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.29%

D. How many bed-hold days during this year were paid by Public Aid?

NONE (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/01/1979

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 9/01/1979 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 130 and days of care provided 5,200Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 10/31/2004 Fiscal Year: 10/31/2004

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2003

Ending:

10/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	320,060	30,955	1,218	352,233		352,233		352,233		1
2	Food Purchase		197,900		197,900	(25,727)	172,173	(1,203)	170,970		2
3	Housekeeping	264,836	16,020	41	280,897		280,897		280,897		3
4	Laundry	115,355	18,359	874	134,588		134,588	(9,294)	125,294		4
5	Heat and Other Utilities			148,147	148,147		148,147		148,147		5
6	Maintenance	93,877	34,553	74,333	202,763		202,763	(10,195)	192,568		6
7	Other (specify):* Rolling Hills Place			692,183	692,183		692,183	(692,183)			7
8	TOTAL General Services	794,128	297,787	916,796	2,008,711	(25,727)	1,982,984	(712,875)	1,270,109		8
	B. Health Care and Programs										
9	Medical Director			5,650	5,650		5,650		5,650		9
10	Nursing and Medical Records	2,601,694	175,841	277,235	3,054,770	(188,430)	2,866,340		2,866,340		10
10a	Therapy			309,899	309,899		309,899		309,899		10a
11	Activities	91,385	12,768	7,230	111,383		111,383		111,383		11
12	Social Services	56,921		1,142	58,063		58,063		58,063		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Rolling Hills Place			250,316	250,316		250,316	(250,316)			15
16	TOTAL Health Care and Programs	2,750,000	188,609	851,472	3,790,081	(188,430)	3,601,651	(250,316)	3,351,335		16
	C. General Administration										
17	Administrative	123,022		150,294	273,316		273,316	(150,294)	123,022		17
18	Directors Fees			25,972	25,972		25,972		25,972		18
19	Professional Services			87,645	87,645		87,645		87,645		19
20	Dues, Fees, Subscriptions & Promotions			53,096	53,096		53,096	(38,851)	14,245		20
21	Clerical & General Office Expenses	333,383	40,689	125,068	499,140		499,140	(33,724)	465,416		21
22	Employee Benefits & Payroll Taxes			796,448	796,448	25,727	822,175		822,175		22
23	Inservice Training & Education										23
24	Travel and Seminar			17,574	17,574		17,574		17,574		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			74,367	74,367		74,367	18,931	93,298		26
27	Other (specify):* Rolling Hills Place			390,641	390,641		390,641	(390,641)			27
28	TOTAL General Administration	456,405	40,689	1,721,105	2,218,199	25,727	2,243,926	(594,579)	1,649,347		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,000,533	527,085	3,489,373	8,016,991	(188,430)	7,828,561	(1,557,770)	6,270,791		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number **ROLLING HILLS MANOR**

#0025239

Report Period Beginning: 11/01/2003 Ending: 10/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			203,469	203,469		203,469	6,847	210,316			30
31	Amortization of Pre-Op. & Org.											31
32	Interest and bond costs			69,631	69,631		69,631	(69,631)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Rolling Hills Pl.			358,114	358,114		358,114	(358,114)				36
37	TOTAL Ownership			631,214	631,214		631,214	(420,898)	210,316			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			450	450		450		450			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,240	71,240		71,240		71,240			42
43	Other (specify):* Prescription drugs					188,430	188,430		188,430			43
44	TOTAL Special Cost Centers			71,690	71,690	188,430	260,120		260,120			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,000,533	527,085	4,192,277	8,719,895		8,719,895	(1,978,668)	6,741,227			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2003

Ending:

10/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients	(10,195)	6		7
8 Laundry for Non-Patients	(9,294)	4		8
9 Non-Straightline Depreciation	6,847	30		9
10 Interest and Other Investment Income	(69,631)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,203)	2		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(150,294)	17		24
25 Fund Raising, Advertising and Promotional	(38,851)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule		43		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (272,621)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(1,706,047)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (1,706,047)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (1,978,668)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4
	Yes	No	Amount	Reference
38 Medically Necessary Transport.			\$	38
39				39
40 Gift and Coffee Shops				40
41 Barber and Beauty Shops				41
42 Laboratory and Radiology				42
43 Prescription Drugs	x		(188,430)	10 43
44 Exceptional Care Program				44
45 Other-Attach Schedule				45
46 Other-Attach Schedule				46
47 TOTAL (C): (sum of lines 38-46)			\$ (188,430)	47

ROLLING HILLS MANOR

ID# 0025239

Report Period Beginning: 11/01/2003

Ending: 10/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2003

Ending:

10/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	1
2	Food Purchase	(1,203)	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	2
3	Housekeeping	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	3
4	Laundry	(9,294)	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	4
5	Heat and Other Utilities	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	5
6	Maintenance	(10,195)	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	6
7	Other (specify):*	0	(692,183)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	7
8	TOTAL General Services	(20,692)	(692,183)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	8
	B. Health Care and Programs													
9	Medical Director	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	9
10	Nursing and Medical Records	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	10
10a	Therapy	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	10a
11	Activities	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	11
12	Social Services	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	12
13	Nurse Aide Training	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	13
14	Program Transportation	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	14
15	Other (specify):*	0	(250,316)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	15
16	TOTAL Health Care and Programs	0	(250,316)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	16
	C. General Administration													
17	Administrative	(150,294)	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	17
18	Directors Fees	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	18
19	Professional Services	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	19
20	Fees, Subscriptions & Promotions	(38,851)	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	20
21	Clerical & General Office Expenses	0	(33,724)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	21
22	Employee Benefits & Payroll Taxes	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	22
23	Inservice Training & Education	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	23
24	Travel and Seminar	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	24
25	Other Admin. Staff Transportation	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	25
26	Insurance-Prop.Liab.Malpractice	0	18,931	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	26
27	Other (specify):*	0	(390,641)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	27
28	TOTAL General Administration	(189,145)	(405,434)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(209,837)	(1,347,933)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF!	29

Summary B

10/31/2004

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	6,847	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 30
31	Amortization of Pre-Op. & Org.	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 31
32	Interest	(69,631)	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 32
33	Real Estate Taxes	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 33
34	Rent-Facility & Grounds	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 34
35	Rent-Equipment & Vehicles	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 35
36	Other (specify):*	0	(358,114)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 36
37	TOTAL Ownership	(62,784)	(358,114)	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 38
39	Ancillary Service Centers	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 39
40	Barber and Beauty Shops	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 40
41	Coffee and Gift Shops	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 41
42	Provider Participation Fee	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 42
43	Other (specify):*	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 43
44	TOTAL Special Cost Centers	0	0	#REF!	#REF!	#REF!	0	0	0	0	0	0	#REF! 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(272,621)	(1,706,047)	#REF!	#REF!	#REF!	0	0	0	0	0	0	45

Facility Name & ID Number ROLLING HILLS MANOR# 0025239

Report Period Beginning:

11/01/2003

Ending:

10/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>SLOVAK AMERICAN CARITABLE ASSOCIATION</u>	<u>100</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>
<u>N/A</u>	<u>NA</u>	<u>N/A</u>	<u>N/A</u>	<u>ROLLING HILLS PLACE</u>	<u>ZION, ILLINOIS</u>	<u>ASSISTED LIVING FACILITY</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	<u>ADMINISTRATIVE EXPENSES</u>	<u>\$ 33,724</u>	<u>SLOVAK AMERICAN CHARITABLE ASSOCIATION</u>	<u>100.00%</u>	<u>\$ (33,724)</u>	1
2	V	7	<u>GENERAL SERVICES</u>	<u>692,183</u>	<u>ROLLING HILLS PLACE</u>	<u>N/A</u>	<u>(692,183)</u>	2
3	V	15	<u>HEALTHCARE & PROGRAMS</u>	<u>250,316</u>	<u>ROLLING HILLS PLACE</u>	<u>N/A</u>	<u>(250,316)</u>	3
4	V	27	<u>GENERAL ADMINISTRATION</u>	<u>390,641</u>	<u>ROLLING HILLS PLACE</u>	<u>N/A</u>	<u>(390,641)</u>	4
5	V	36	<u>CAPITAL EXPENSES</u>	<u>358,114</u>	<u>ROLLING HILLS PLACE</u>	<u>N/A</u>	<u>(358,114)</u>	5
6	V	26	<u>LIABILITY INSURANCE</u>	<u>(18,931)</u>	<u>SLOVAK AMERICAN CHARITABLE ASSOCIATION</u>	<u>100.00%</u>	<u>18,931</u>	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		<u>\$ 1,706,047</u>			<u>\$</u>	<u>\$ * (1,706,047)</u>	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2003 Ending: 10/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	GEORGE JANAC	DIRECTOR	PRESIDEN	NONE	NONE	1/2 HR.	2.00	DIR. FEE	\$ 1,550		1
2	GEORGE JANAC	DIRECTOR	BUSINESS MGR.	NONE	NONE	8 HRS.	20.00	BUS. MGR.	11,665		2
3	ANNE SCOTT	DIRECTOR	VICE PRES.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,775		3
4	ANNE SCOTT	DIRECTOR	NURSING ADV.	NONE	NONE	1/4 HR.	1.00	NURS. ADV.	457		4
5	JUDITH JANAC	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,650		5
6	ANN MEDO	DIRECTOR	TREASURER	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,700		6
7	JAMES STEFO, SR.	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,300		7
8	JAMES STEFO, JR	DIRECTOR	SECRETARY	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,475		8
9	ELEANOR PETRAS	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,900		9
10	NAN STEFO	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	425		10
11	JANET PILCH	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,700		11
12	JANA CHARVAT	DIRECTOR	MGMT. COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	375		12
13								TOTAL	\$ 25,972		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2003 Ending: 0/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	IDFA REVNUe BONDS			REFINANCING OF SERIES	\$11,000.00	6/29/2000	\$ 2,600,000	\$ 2,466,610	6/29/2030	VAR.	\$ 29,310	1	
2	SERIES 2000		X	1991 REVENUE BONDS								2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$11,000.00		\$ 2,600,000	\$ 2,466,610			\$ 29,310	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,600,000	\$ 2,466,610			\$ 29,310	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239** Report Period Beginning: **11/01/2003** Ending: **10/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$	NONE		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	NONE		2
3. Under or (over) accrual (line 2 minus line 1).		\$	NONE		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	NONE		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	NONE		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	NONE		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1999	NONE	8		
	2000	NONE	9		
	2001	NONE	10		
	2002	NONE	11		
	2003	NONE	12		
				FOR OHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROLLING HILLS MANOR COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0025239

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet: 51,632
 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories ONE

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ROLLING HILLS PLACE

ASISTED LIVING FACILITY

48000 SQUARE FEET

69 BEDS / 61 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	3 ACRES	1979	\$ 100,763	1
2					2
3	TOTALS	3 ACRES		\$ 100,763	3

Facility Name & ID Number ROLLING HILLS MANOR

0025239

Report Period Beginning:

11/01/2003 Ending: 10/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		1979	1970	\$ 927,078	\$ 10,896	40	\$ 17,743	\$ 6,847	\$ 796,327	4
5	PREMIUM		1979	1979	712,648	20,362	35	20,362		509,032	5
6	RENOVATIONS		1992	1992	1,234,270	30,857	40	30,857		385,709	6
7	RENOVATIONS		1992	1992	232,299		10			232,299	7
8	RENOVATIONS		1998	1998	695,702	17,393	40	17,393		105,122	8
	Improvement Type**										
9	AIRLOCK			1982	3,886		20			3,886	9
10	ROOF			1983	41,724		20			41,724	10
11	PLUMBING FIXTURES			1983	3,845		20			3,845	11
12	ROOF AND HEATER			1984	118,647	2,967	20	2,967		118,647	12
13	AIR CONDITIONING UNITS			1984	37,141		10			37,141	13
14	HEATING UNITS			1985	1,061		10			1,061	14
15	RAMP			1985	38,992	1,950	20	1,950		38,005	15
16	MIXING VALVE			1985	325	14	20	14		325	16
17	FENCE			1986	1,257	63	20	63		1,167	17
18	RAMP			1986	5,400	270	20	270		4,990	18
19	ROOF			1986	33,997	1,697	20	1,697		31,436	19
20	HEATING UNITS			1988	6,344		3			6,344	20
21	FLOOD DEVICE			1989	7,418		10			7,418	21
22	ELECTRIC PANEL			1989	6,354		5			6,354	22
23	HALLWAY LIGHTING			1990	8,091		10			8,091	23
24	ALARM SYSTEM			1991	6,775		10			6,775	24
25	PELLA WINDOWS			1992	4,367		10			4,367	25
26	PELLA WINDOWS			1992	3,661		5			3,661	26
27	ROOF			1993	24,500		10			24,500	27
28	PELLA WINDOWS			1993	14,624	731	20	731		8,409	28
29	ROOF			1994	24,500	1,225	10	1,225		23,275	29
30	HEATERS			1994	6,987	298	10	298		6,750	30
31	WATER LINE			1994	6,820	341	20	341		3,581	31
32	PARKING LOT SURFACE			1994	4,346	217	20	217		1,564	32
33	ROOF			1995	24,800	2,480	10	2,480		23,560	33
34	HOT WATER SYSTEM			1995	18,175	1,818	10	1,818		17,266	34
35	DOOR LOCKS			1995	12,473	1,189	10	1,189		11,878	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

11/01/2003 Ending: 10/31/2004

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

****Improvement type must be detailed in order for the cost report to be considered complete.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,642,715	\$ 122,534		\$ 129,381	\$ 6,847	\$ 2,586,919	1
2	CARPETING	2004	27,900	1,395	10	1,395		1,395	2
3	DOORS	2004	11,800	295	20	295		295	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,682,415	\$ 124,224		\$ 131,071	\$ 6,847	\$ 2,588,609	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 606,885	\$ 5,869	\$ 5,869	\$		\$ 606,885	71
72	Current Year Purchases	38,134	2,800	2,800			2,800	72
73	Fully Depreciated Assets	999,235	70,576	70,576			675,669	73
74								74
75	TOTALS	\$ 1,644,254	\$ 79,245	\$ 79,245	\$		\$ 1,285,354	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BUSINESS	1995 FORD ELDORADO	1995	\$ 40,018	\$	\$	\$		\$ 40,018	76
77										77
78										78
79										79
80	TOTALS			\$ 40,018	\$	\$	\$		\$ 40,018	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,467,450	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 203,469	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 210,316	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,847	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,913,981	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ NONE	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	NONE	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL		N/A		\$ N/A			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$ N/A	\$ N/A	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$

13. /2006 \$

14. /2007 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$	NONE		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	NONE

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A	hrs	\$ 143,106		\$	\$		\$ 143,106	1
2	Licensed Speech and Language Development Therapist	10A	hrs	7,294					7,294	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	hrs	159,499					159,499	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):									13
14	TOTAL			\$ 309,899		\$	\$		\$ 309,899	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 106,181	\$ 245,944	1
2	Cash-Patient Deposits	15,501	15,501	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 180,000)	1,160,000	1,175,089	3
4	Supply Inventory (priced at)	36,826	79,730	4
5	Short-Term Investments		21,799	5
6	Prepaid Insurance	20,959	20,959	6
7	Other Prepaid Expenses	4,604	4,604	7
8	Accounts Receivable (owners or related parties)	21,952	49,244	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,366,023	\$ 1,612,870	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,456,309	12
13	Land	100,763	236,453	13
14	Buildings, at Historical Cost	4,682,415	10,896,485	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,684,272	2,396,323	16
17	Accumulated Depreciation (book methods)	(3,913,981)	(4,619,540)	17
18	Deferred Charges	177,729	444,396	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,731,198	\$ 10,810,426	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,097,221	\$ 12,423,296	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 102,908	\$ 132,229	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,501	15,501	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,328	233,960	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,641	11,483	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	RESIDENT AND OTHER CREDITS	250,295	417,430	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 582,673	\$ 810,603	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,466,610	7,780,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,466,610	\$ 7,780,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,049,283	\$ 8,590,603	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,047,938	\$ 3,832,693	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,097,221	\$ 12,423,296	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,935,168	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,935,168	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(102,475)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (102,475)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,832,693	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,194,186	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,194,186	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,237,571	6
7	Oxygen	37,657	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,275,228	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	10,195	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	9,294	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 19,489	23
	D. Non-Operating Revenue		
24	Contributions	45,290	24
25	Interest and Other Investment Income***	83,227	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 128,517	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,617,420	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,008,711	31
32	Health Care	3,790,081	32
33	General Administration	2,218,199	33
	B. Capital Expense		
34	Ownership	631,214	34
	C. Ancillary Expense		
35	Special Cost Centers	71,240	35
36	Provider Participation Fee	450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,719,895	40
41	Income before Income Taxes (line 30 minus line 40)**	(102,475)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (102,475)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **ROLLING HILLS MANOR**# **0025239**Report Period Beginning: **11/01/2003**Ending: **10/31/2004**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,880	2,184	\$ 65,941	\$ 30.19	1
2	Assistant Director of Nursing	1,928	2,168	58,811	27.13	2
3	Registered Nurses	16,633	17,584	454,615	25.85	3
4	Licensed Practical Nurses	19,455	21,860	467,652	21.39	4
5	Nurse Aides & Orderlies	109,835	115,928	1,384,031	11.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,937	7,617	109,724	14.41	8
9	Activity Director	1,680	2,024	23,254	11.49	9
10	Activity Assistants	6,421	6,859	68,131	9.93	10
11	Social Service Workers	2,784	2,977	56,921	19.12	11
12	Dietician	1,138	1,173	28,797	24.55	12
13	Food Service Supervisor	2,120	2,200	42,463	19.30	13
14	Head Cook	7,509	7,863	96,025	12.21	14
15	Cook Helpers/Assistants	18,383	19,436	152,775	7.86	15
16	Dishwashers					16
17	Maintenance Workers	10,531	11,379	93,877	8.25	17
18	Housekeepers	31,029	33,100	264,836	8.00	18
19	Laundry	11,562	13,007	115,355	8.87	19
20	Administrator	2,208	2,416	85,282	35.30	20
21	Assistant Administrator					21
22	Other Administrative	11,721	12,465	245,941	19.73	22
23	Office Manager	2,032	2,160	59,873	27.72	23
24	Clerical	4,310	4,658	1,728	0.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,024	2,320	60,920	26.26	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,883	1,979	25,841	13.06	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Exec. Director</u>	844	864	37,740	43.68	33
34	TOTAL (lines 1 - 33)	274,847	294,221	\$ 4,000,533 *	\$ 13.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	75	5,650	9 : 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	29	2,913	10a : 3	40
41	Occupational Therapy Consultant	21	2,063	10a : 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	536	11 : 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	146	\$ 11,162		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 769	10 : 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 769		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
SUE HARRIS	ADMINISTRATOR	NONE	\$ 55,773	Workers' Compensation Insurance	\$	95,304	IDPH License Fee	\$ 6,911
CAROLYN LOFLAND	ADMINISTRATOR	NONE	29,509	Unemployment Compensation Insurance		31,497	Advertising: Employee Recruitment	
JAMES STEFO, SR.	EXECUTIVE DIR.	NONE	37,740	FICA Taxes		299,568	Health Care Worker Background Check (Indicate # of checks performed _____)	
				Employee Health Insurance		274,483	ADVERTISING	39,427
				Employee Meals		25,727	INSPECTIONS AND FEES	1,480
				Illinois Municipal Retirement Fund (IMRF)*			LIFE SERVICES NETWORK	4,133
				RETIREMENT FUNDING		31,545	MEMBERSHIPS	1,145
				BENEFIT ACCRUAL EXPENSE		64,051		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 123,022					
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount				Non-allowable advertising	(19,549)
			\$				Yellow page advertising	(19,302)
BAD DEBT EXPENSE			150,294					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 150,294	TOTAL (agree to Schedule V, line 22, col.8)	\$	822,175	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,245
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ALTSCHULER, MELVOIN, AND GLASSER	AUDITING FEES		28,995				Out-of-State Travel	\$
JAMES S. STEFO AND CO.	ACCOUNTING FEES		44,790					
WESSELS AND PAUTCH	LEGAL FEES		10,353				In-State Travel	
DUANE MORRIS, LLP	LEGAL FEES		606				AUTO EXPENSE	1,989
BANK ONE	BOND FEES		38				TRAVEL REIMBURSEMENT	2,899
GARDNER AND WHITE	401 K FEES		908				Seminar Expense	12,686
REVERE HEALTHCARE	COLLECTION FEES		1,955					
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 87,645	TOTAL		\$	TOTAL	\$ 17,574

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **ROLLING HILLS MANOR**

STATE OF ILLINOIS

0025239

Report Period Beginning: **11/01/2003**

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Ending: **10/31/2004**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN \$4,133
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 - 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,491 Line 10 - 3
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 71,240
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 25,727 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: ALTSCHULER, MELVOIN, AND GLASSER The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. COMPLETED, AWAITING DELIVER
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

#####

RECLASSIFICATIONS

SCHEDULE V COLUMN 5, LINES 2 AND 22

\$25,727 OF EMPLOYEE MEALS HAVE BEEN DEDUCTED FROM LINE 2

(FOOD COSTS) AND HAVE BEEN ADDED TO LINE 22 (EMPLOYEE BENEFITS).

SCHEDULE V COLUMN 5, LINES 10 AND 43

\$188,430 OF PRESCRIPTION DRUG COSTS HAVE BEEN DEDUCTED FROM

LINE 10 (NURSING COSTS) AND HAVE BEEN ADDED TO LINE 43

(SPECIAL COST CENTERS - OTHER).